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	155757	A. BUILDING 00 B. WING	03/01/2013

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ROSEGATE VILLAGE	7510 ROSEGATE DR INDIANAPOLIS, IN 46237

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 25, 26, 27, 28, and March 1, 2013. Facility number: 011149 Provider number: 155757 AIM number: 200829340 Survey Team: Leia Alley, RN-TC Patty Allen, BSW Marcy Smith, RN Dinah Jones, RN Census Bed Type: SNF: 38 SNF/NF: 105 Total: 143 Census Payor Type: Medicare: 37 Medicaid: 75 Other: 31 Total: 143 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on March 06, 2013; by Kimberly Perigo, RN.	F000000	Rosegate Village respectfully requests desk review in lieu of an onsite visit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a comprehensive care plan for 1 of 5 residents, receiving anti-coagulant medications, in a sample of 10 residents reviewed for unnecessary medications. (Resident #73.) Findings include: A clinical record review on 2/28/13 at 2:00 p.m., indicated a comprehensive care plan (the statement of the goals and objectives of the nursing care provided to the patient and the	F000279	**F279** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #73 had a comprehensive care plan developed for receiving anti-coagulant medications. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A chart audit identified residents who receive anti-coagulant medications.	03/25/2013

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	interventions required to accomplish the plan) had not been initiated for Resident #73, who was receiving the anti-coagulant medication, warfarin. The resident's diagnoses included, but were not limited to: acute embolism/deep vein thrombosis [blood clot] to her lower extremity [leg], atrial fibrillation [irregular heartbeat], and congestive heart failure. The Director of Nursing indicated, in an interview on 3/1/13 at 11:00 a.m., a comprehensive care plan had not been initiated for Resident #73, for the anti-coagulant medication, warfarin. 3.1-35(a)		· Residents with anti-coagulant medications had a comprehensive care plan developed for receiving anti-coagulant medications. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Director of Nursing Services (DNS) reviewed the policies on developing comprehensive care plans focused on anti-coagulant medications. · Nursing staff, MDS Coordinator, and MDS Assistants were inserviced on or before 3/25/13 by the DNS on developing temporary and permanent comprehensive care plans for residents receiving anti-coagulant medications · On all new admissions nursing staff will develop a temporary care plan for residents receiving anti-coagulant medications until the permanent comprehensive care plan is developed. · IDT team will ensure care plan is developed when a resident is receiving anti-coagulant medication. · Residents receiving anti-coagulant medications will be reviewed no less than quarterly and/or with significant change by nurse managers to ensure the comprehensive care plan is developed for receiving anti-coagulant medications.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DNS/Qualified Designee is responsible for the completion of the Coumadin Therapy Continuous Quality Improvement (CQI) audit tool for residents who receive anti-coagulant medications one unit per day for four weeks, monthly for two months, then quarterly thereafter for at least six months with results reported to the CQI committee overseen by the executive director. If threshold is not achieved of 95% an action plan may be developed to ensure compliance.	

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure residents' anxiety symptoms were assessed for cause, and alternative, non-pharmacological interventions were offered to the residents prior to the administration of as needed anti-anxiety medications. This affected 2 of 10 residents who met the criteria for review of unnecessary medication. (Residents #155 and #112.)	F000329	**F329** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #155 currently does not currently reside at the facility. · Resident #112 has non-medication interventions offered and documented prior to administration of anti-anxiety medication. **How will you identify other residents having the potential to be affected by the same deficient**	03/25/2013

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	Findings include: 1) The clinical record of Resident #155 was reviewed on 2/28/11 at 11:00 a.m. Diagnoses for Resident #155 included, but were not limited to anxiety and chronic obstructive pulmonary disease. An admission Minimum Data Set assessment, dated 2/19/13, indicated Resident #155 was independent with his decision making skills. A physician's order, dated 2/20/13, indicated Resident #155 could receive Ativan (an anti-anxiety medication), 0.5 milligrams (mg) every 8 hours, as needed, for anxiety. A care plan, dated 2/22/13, indicated a problem of Resident #155 being at risk for signs and symptoms of anxiety. Interventions included, "Intervention #1 during acute phase do not place demands on resident. Remove from excess stimulation...Intervention #2 administer medications as ordered for anti-anxiety medications...Intervention #3 encourage resident to voice feelings/frustrations/concerns and		**practice and what corrective action will be taken?** · A chart audit identified residents who require as needed (PRN) anti-anxiety medication. · Residents with PRN anti-anxiety medication will be offered non-pharmacological interventions as directed per individualized plan of care and documented effectiveness. If non-pharmacological interventions are not effective PRN anti-anxiety medication may be given per physician with the effectiveness of the medication documented. · Nursing staff was inserviced on or before 3/25/13 by the DNS and Social Services on residents with PRN anti-anxiety medication being offered non-pharmacological interventions as directed per individualized plan of care and documenting the effectiveness. If non-pharmacological interventions are not effective PRN anti-anxiety medication may be given per physician order with the effectiveness of the medication documented. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Director of Nursing Services (DNS) reviewed the policies on Medication Administration. · Nursing staff was inserviced	

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	address as appropriate..." A Medication Administration Record (MAR) for February, 2013, indicated Resident #155 received Ativan, 0.5 mg., on 2/21, 2/24, and 2/26, 2013. Nurses' documentation on the back of the MAR indicated on 2/21/13 he received Ativan for complaints of "anxiety" and it was effective and on 2/24/13 he received Ativan for "nerves" and it was effective. No documentation was found in regards to the administration of Ativan on 2/26/13. No documentation was found in Resident #155's record to indicate the cause of his anxiety was assessed or alternative, non-pharmacological methods were attempted prior to administering the as needed anti-anxiety medication. During an interview with the DON on 2/28/13 at 3:35 p.m., she indicated anxiety symptoms should be assessed for cause and severity, and non-pharmacological interventions should be considered, prior to administering as needed anxiety medication. She indicated the facility did not have a policy regarding offering non-pharmacological		on the Behavior Management Policy and Procedure on or before 3/25/13 by the DNS and Social Services on residents with PRN anti-anxiety medication being offered non-pharmacological interventions as directed per individualized plan of care and documenting the effectiveness. If non-pharmacological interventions are not effective PRN anti-anxiety medication may be given with the effectiveness of the medication documented. · Will request from physician that the duration of the PRN Anti-anxiety medications not to exceed seven days. · Behavior management team will review non-pharmacological interventions for residents requiring PRN anti-anxiety medications and will included them on our behavior monitoring flow sheets. · Any new order for PRN anti-anxiety medications usage is reviewed no less than weekly by nurse managers for necessity and appropriateness of continued use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/Qualified Designee is responsible for the completion of the Unnecessary Medication audit tool for non- pharmacological interventions for one unit per day	

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	alternatives prior to administering anti-anxiety medications. She indicated, "We need to do this. I will start inservices now." 2) The clinical record for Resident #112 was reviewed on 2/27/12 at 3:15 p.m. Diagnoses for Resident #112 included but were not limited to acute hypoxia (lack of oxygen), respiratory failure, and anxiety. A physicians order written on 11/23/12, indicated Resident #112 could have "Ativan 0.5 mg, 1 tablet by mouth every six hours as needed for anxiety." The Medication Administration Record (MAR) indicated Resident #112 received the medication on 12/11/12, 12/20/12, and 1/14/13. The record indicated the medication was given for an increase of anxiety, but had no further information in regards to the cause of Resident #112's anxiety or if any alternative measures		for four weeks, monthly for two months, then quarterly thereafter for at least six months with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold of 95% is not achieved an action plan may be developed to ensure compliance.	

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	had been offered. During an interview on 2/28/13 at 10:00 a.m., with the DNS (Director of Nursing Services), she indicated there was no further information available in regards to interventions done prior to giving the medication. An untitled facility policy, dated 7/20/11, received from the Director of Nursing (DON) on 2/28/13 at 3:25 p.m., indicated "...A nursing assessment of the resident and symptoms prior to administration and results are to be documented..." 3.1-48(b)(1)			

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F000364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on interview and observation, the facility failed to provide residents with food meeting their taste requirements for palatability for 4 of 19 residents interviewed. This had the potential to affect 10 of 10 residents who received noon meal room trays from the kitchen in the facility population of 143. (Residents #13, #63, #186, and #283) Findings include: On 02/26/13 at 10:00 a.m., an interview with Resident #186, they indicated the room trays were cold. The food flavor is not as good when it should be served hot, but was served cold. On 02/26/13 at 9:00 a.m, during an interview with Resident #283, they indicated the room trays were cold. The food flavor is not as good when it should be served hot, but was served cold. On 02/26/13 at 10:00 a.m., during an	F000364	**F364** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #186 registered dietician interviewed resident on food temperatures. Residents stated they are now receiving all hot and cold food items meeting their taste requirements for palatability at the time the resident receives their room tray. · Resident #283 supervisor interviewed resident on food likes and dislikes related to food temperatures. Interview was documented in chart and updated on tray card and care plan. · Resident#63 supervisor interviewed resident on food likes and dislikes related to food temperatures. Interview was documented in chart and updated on tray card and care plan. · Resident #13 supervisor interviewed resident on food likes and dislikes related to food temperatures. Interview was documented in chart and updated on tray card and care plan. · Plate warmer is turned on to	03/25/2013

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	interview with Resident #63, they indicated the room trays were cold. The food flavor is not as good when it should be served hot, but was served cold. On 02/26/13 at 3:00 p.m., during an interview with Resident #13, they indicated the room trays were cold. The food flavor is not as good when it should be served hot, but was served cold. On 02/26/13 at 12:20 p.m., food on the steam table was measured for temperature. The sour kraut measured 140 degrees Fahrenheit, mashed potatoes 150 degrees Fahrenheit, and smoked sausage 150 degrees Fahrenheit. The room tray cart left the kitchen at 12:40 p.m., and all room trays were served at 12:48 p.m. At 12:50 p.m., the temperatures of the food on the test tray were measured. The sauerkraut measured 112 degrees Fahrenheit, mashed potatoes 121 degrees Fahrenheit, and smoked sausage 120 degrees Fahrenheit. On 02/26/13 at 1:00 p.m., during an interview with the dietary manger, assistance manger and consultant dietitian, they indicated the temperatures of the test tray were low		ensure hot food is served at a palatability temperature · Replaced heat on demand trays. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who receive room trays have the potential to be affected. A facility audit identified residents who receive room trays. · Residents who receive room trays will be served all hot and cold food items meeting their taste requirements for palatability at the time the resident receives the food. · Plate warmer is turned on to ensure hot food is served at a palatability temperature · Replaced heat on demand trays. · Dietary staff was inserviced on or before 3/25/13 by the dietary services manager on the proper use of the plate warmer, heat on demand system and on food temperature requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Identified plate warmer was not turned on. · Assigned dietary aide to turn plate warmer on 1 hour prior to	

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	and the food was cold. They understood some of the residents complained and they accepted the validity of their complaints. On 02/27/13 at 9:00 a.m., the consultant dietitian indicated the staff had been turning off the plate warmer and that is the reason for the low temperatures and cold food. On 02/27/13 at 4:00 p.m., the facility Administrator indicated he agreed with the consultant dietitian and dietary manager that the low temperatures and cold food on the test tray, were the result of staff turning off the plate warmer. 3.1-21(a)(2)		meal service. · Dietary supervisor/designee will ensure plate warmer is turned on. · The Executive Director (ED) reviewed the dietary policies on proper food temperatures with the dietary services manager. · Dietary staff was inserviced on or before 3/25/13 by the dietary services manager on the proper use of the plate warmer, heat on demand system and on food temperature requirements. · When staff delivers room tray to resident they will ask them if all hot and cold food items meet their taste requirements for palatability they will get them a replacement tray that meets their preferences. · Customer Care representatives will interview residents during customer care rounds regarding all hot and cold food items meeting their taste requirements for palatability at the time the resident receives their room tray. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Executive Director /Qualified Designee are responsible for the completion of the Temperature Monitoring audit tool for residents who receive a room	

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			tray. One room tray will be tested daily during a scheduled meal service for four weeks, monthly for two months, then quarterly thereafter for at least six months with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold of 95% is not achieved an action plan may be developed to ensure compliance.	